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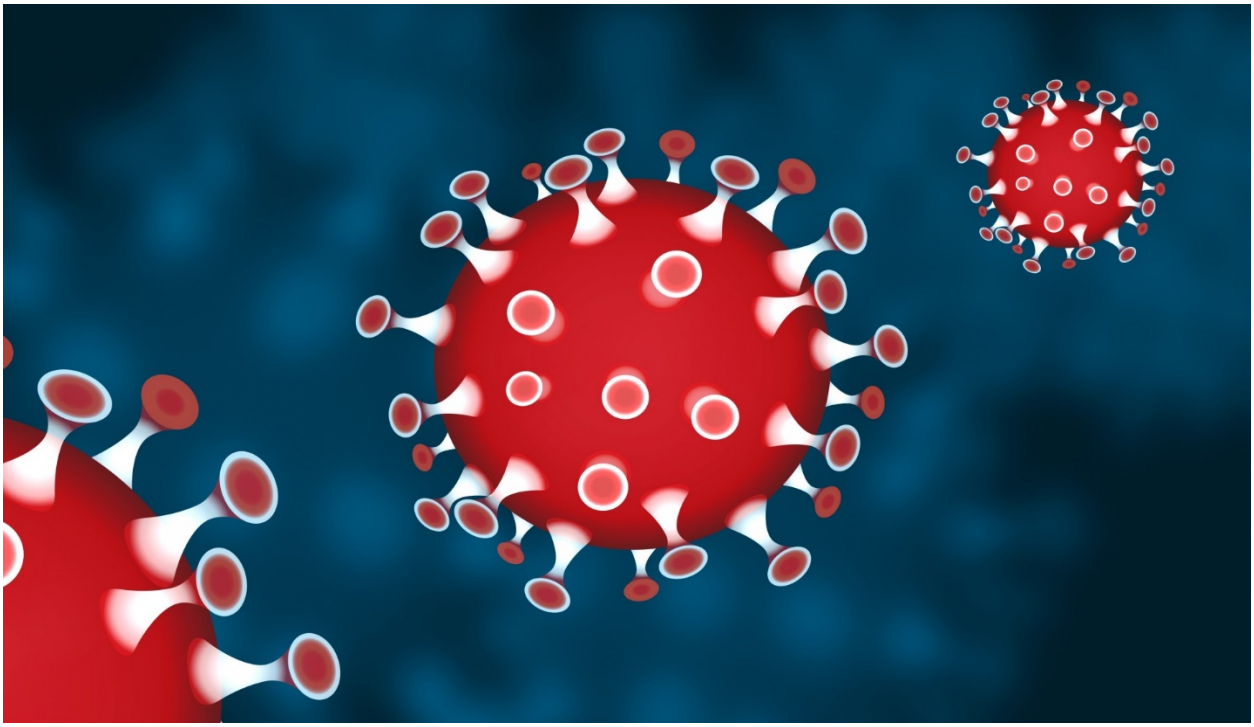
Infection Prevention and Control Plan for Residential Facilities Coronavirus Disease 2019 (COVID-19) Response Best Practices

September 20, 2021



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Introduction

Because group homes involve different individuals living together and sharing activities (congregate living), group homes are at high risk of COVID-19 spreading and affecting their residents as well as staff. If residents become infected with COVID-19 they may be at increased risk of developing a serious illness or dying as residents in group homes tend to be older, or have physical, psychiatric or intellectual disabilities and may have underlying chronic medical conditions.

COVID-19 spreads mainly through close person-to-person contact in respiratory droplets from someone who is infected. People who are infected often have symptoms of illness, but even some people without symptoms may be able to spread the virus. Person-to-person spread occurs between people who are in close contact with one another such as within about six feet and through respiratory droplets produced when an infected person coughs, sneezes or talks. A person can get COVID-19 by touching a surface or object that has the virus on it and then touching their own mouth, nose or possibly their eyes. However, this is not thought to be the main way the virus spreads.

Having an infection prevention and control plan individualized to your facility is important for the protection of your staff and residents**. COVID-19 may continue to present itself in the future and it is important to have your facility prepared to keep COVID-19 from entering your facility, if possible. If COVID-19 infection enters the facility, the key is recognizing and taking immediate action to rapidly contain the spread.**

This generic infection prevention and control plan for group homes is meant to assist each facility in developing its own individualized plan to meet the needs of the facility residents and staff.

COVID-19 post-vaccine infection control recommendations

Post-vaccinated health care providers (HCP) and caregivers should continue to follow CDC infection prevention and control recommendations on preventing the transmission of COVID-19. This is also applicable to vaccinated residents who should continue to follow current CDC guidance to protect themselves and others, including wearing a mask, staying at least 6 feet away from others, avoiding crowds, avoiding poorly ventilated spaces, practicing cough etiquette by covering coughs and sneezes as well as performing hand hygiene. This is due to the fact that here is currently limited information on how much the vaccines might reduce transmission and how long protection lasts. In addition, the efficacy of the vaccines against emerging SARS-CoV-2 variants is not known.

CDC's current recommendations will continue to be the primary way that Long Term Care Facility (LTCF) residents and HCP are protected until vaccination is widespread. These recommendations are described in the Considerations for Preventing the Spread of COVID-19 in Assisted Living Facilities and Interim Infection Prevention and Control Recommendations for Health care Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic.

Fully vaccinated residents of residential facilities

Fully vaccinated residents of residential facilities should continue to quarantine for 14 days and be tested for SARS-CoV-2 following an exposure to someone with suspected or confirmed COVID-19. This is because residential congregate settings may face high turnover of residents, a higher risk of transmission and challenges in maintaining recommended physical distancing.

Staff have an option to not quarantine if they meet the three criteria below. They should be monitored for 14 days and clinically evaluated and tested if symptoms develop.

Currently, authorized vaccines in the United States are highly effective at protecting vaccinated people against symptomatic and severe COVID-19. Additionally, a growing body of evidence suggests that fully vaccinated people are less likely to have asymptomatic infection and potentially less likely to transmit SARS-CoV-2 to others. How long vaccine

protection lasts and how much vaccines protect against emerging SARS-CoV-2 variants are still under investigation. Until more is known, and vaccination coverage increases, some prevention measures will continue to be necessary for all people, regardless of vaccination status. However, the benefits of reducing social isolation and relaxing some measures such as quarantine requirements may outweigh the residual risk of fully vaccinated people becoming ill with COVID-19 or transmitting SARS-CoV-2 to others. Additionally, taking steps toward relaxing certain measures for vaccinated persons may help improve COVID-19 vaccine acceptance and uptake. Therefore, there are several activities that fully vaccinated people can resume now, at low risk to themselves, while being mindful of the potential risk of transmitting the virus to others.

The Nevada Department of Health and Human Services (DHHS) is defining fully vaccinated for COVID-19 as ≥2 weeks following receipt of the second dose in a two-dose series, or ≥4 weeks following receipt of one dose in a single-dose vaccine:

1. Pfizer-BioNTech: two doses administered three weeks (21 days) apart
2. Moderna: two doses administered one month (28 days) apart
3. Johnson and Johnson (J&J)/Janssen: one dose

In general, work restrictions of asymptomatic caregivers who have recovered from SARS-CoV-2 infection in the prior 90 days or who are fully vaccinated are not necessary unless they develop symptoms, test positive for SARS-CoV-2 infection or are otherwise directed to do so by the jurisdiction's public health authority.
Interim Guidance for Managing Health care Personnel with SARS-CoV-2 Infection or Exposure to SARS-CoV-2 | CDC

Fully vaccinated caregivers and health care personnel (HCP) who do not quarantine should still monitor themselves for symptoms of COVID-19 for 14 days following their last exposure to someone with suspected or confirmed COVID-19. If symptoms develop, they should be clinically evaluated and tested for COVID-19 if indicated.

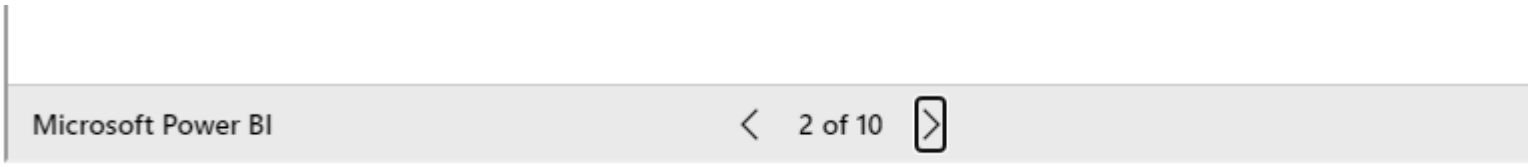
Note - This does not change current recommendations for PPE usage, cohorting or testing in congregate living environments.

Proof of vaccination
Currently, in Nevada there are three mechanisms for proof of full vaccination. The first is the paper vaccination card received and signed off by a health care provider for each type of dose series. The second mechanism is the public portal with NV WebIZ, which supports a secure connection to vaccination records using an email or phone number. The last source of record will be the scheduling tool, MTX/Salesforce, that will hold vaccination history. Please click on the link provided below to review DHHS' Public Health Recommendations for Fully Vaccinated Individuals technical bulletin:
http://dpbh.nv.gov/uploadedFiles/dpbhnvgov/content/Resources/TB-Interim-Guidance-Fully-Vaccinated-03102021.pdf

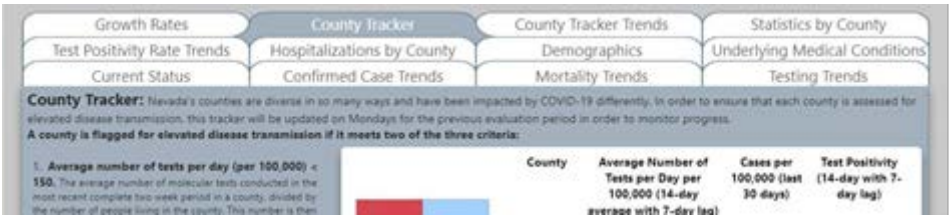
Keep COVID-19 From Entering your Facility

Know your county's COVID-19 positivity rate, which can be found online at https://nvhealthresponse.nv.gov/. You will see the COVID-19 (coronavirus) dashboard on the first page, then click the arrow at the bottom of the dashboard to page 2 (screen shot 1); or click the "County Tracker" tab 9 (screen shot 2).

Screen Shot 1



Screen Shot 2



Your county's COVID-19 positivity rate may change, so it should be monitored regularly in order to adjust your facility's current visitation procedures with your county's positivity rate.

Indoor visitation during an outbreak

An outbreak exists when a new residential facility for group onset of COVID-19 occurs (i.e., a new COVID-19 case among residents or staff). This guidance is intended to describe how visitation can still occur when there is an outbreak, but there is evidence that the transmission of COVID-19 is contained to a single area (e.g., unit) of the facility. To swiftly detect cases, we remind facilities to adhere to CDC regulations and guidance for COVID-19 testing, including routine staff testing, testing of individuals with symptoms, and outbreak testing.

When a new case of COVID-19 among residents or staff is identified, a facility should immediately begin outbreak testing and suspend all visitation (except that required under federal disability rights law), until at least one round of facility-wide testing is completed. Visitation can resume based on the following criteria:

- If the first round of outbreak testing reveals **no additional COVID-19 cases in other areas (e.g., units) of the facility**, then visitation can resume for residents in areas/units with no COVID-19 cases. However, the facility should suspend visitation on the affected unit until the facility meets the criteria to discontinue outbreak testing. For example, if the first round of outbreak testing reveals two more COVID-19 cases in the same unit as the original case, but not in other units, visitation can resume for residents in areas/units with no COVID-19 cases.

- If the first round of outbreak testing **reveals one or more additional COVID-19 cases in other areas/units of the facility** (e.g., new cases in two or more units), then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

While the above scenarios describe how visitation can continue after one round of outbreak testing, facilities should continue all necessary rounds of outbreak testing. In other words, this guidance provides information on how visitation can occur during an outbreak but does not change any expectations for adherence to infection prevention and control practices. If subsequent rounds of outbreak testing identify **one or more additional COVID-19 cases in other areas/units of the facility**, then facilities should suspend visitation for all residents (vaccinated and unvaccinated), until the facility meets the criteria to discontinue outbreak testing.

NOTE: In all cases, visitors should be notified about the potential for COVID-19 exposure in the facility (e.g., appropriate signage regarding current outbreaks), and adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene and use of face-coverings.

We note that compassionate care visits and visits required under federal disability rights law should be **allowed at all times** for any resident (vaccinated or unvaccinated) regardless of the above scenarios. Lastly, facilities should continue to consult with their state or local health departments when an outbreak is identified to ensure adherence to infection control precautions, and for recommendations to reduce the risk of COVID-19 transmission.

1. Limit visitors to the facility to only those essential for the resident's physical or emotional well-being and care (e.g., contract service providers and health inspectors.)
    - Examples of support for emotional well-being include:
        - A resident, who was living with their family before recently being admitted to a facility, is struggling with the change in environment and lack of physical family support.
        - A resident who is grieving after a friend or family member recently passed away.
        - A resident who needs cueing and encouragement with eating or drinking, previously provided by family and/or caregiver(s), is experiencing weight loss or dehydration.
        - A resident, who used to talk and interact with others, is experiencing emotional distress, seldom speaking, or crying more frequently (when the resident had rarely cried in the past).
2. Restrict all volunteers and non-essential personnel including consultant services (e.g., entertainers, barber, nail care).
3. Encourage use of alternative mechanisms for resident interactions such as video-call applications on cell phones or tablets.
4. Limit points of entry to the facility to allow screening of all potential visitors.
5. Screening of all who enter the facility for signs and symptoms of COVID-19 (e.g., temperature checks, questions about and observations of signs or symptoms), and denial of entry of those with signs or symptoms or those who have had close contact with someone with COVID-19 infection in the prior 14 days (regardless of the visitor's vaccination status). Create or review an inventory of all volunteers and staff who provide care in the facility. Use that inventory to determine which staff are non-essential and whose services can be delayed. This inventory can also be used to notify staff if COVID-19 is identified in the facility.
6. Establish procedures for monitoring, managing, and training all visitors, which should include:
    - All visitors should be instructed to wear a facemask or cloth face covering at all times while in the facility, perform frequent hand hygiene, and restrict their access to the area designated by the facility.
    - Informing visitors about appropriate PPE use according to current facility visitor policy.
7. Post signage at all entrances to alert everyone entering the facility (visitors, residents, and staff) regarding screening and restrictions. Signs should remind visitors, residents, and staff not to enter the building if they have fever or symptoms of COVID-19.
8. If the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.

Indoor visitation for counties with a low or medium COVID-19 county positivity rate

Facilities should allow indoor visitation at all times and for all residents (regardless of vaccination status), except for a few circumstances when visitation should be limited due to a high risk of COVID-19 transmission (note: compassionate care visits should be permitted at all times). These scenarios include limiting indoor visitation for:

- *Unvaccinated residents, if the residential facilities for group COVID-19 county positivity rate is greater than 10% **and less** than 70% of residents in the facility are fully vaccinated;*
- *Residents with confirmed COVID-19 infection, whether vaccinated or unvaccinated until they have met the criteria to discontinue Transmission-Based Precautions; or*

- *Residents in quarantine, whether vaccinated or unvaccinated, until they have met criteria for release from quarantine.*

If a facility is not having an outbreak or is in a county with a low (<5%) *or medium* (5% – 10%) COVID-19 county positivity rate allow indoor visitations according to the core principles of COVID-19 infection prevention and facility policies. The following indoor visitation guidelines are recommended.

Facilities should accommodate and support indoor visitation to the best of their abilities while also keeping the residents and staff safe, including visits for reasons beyond emotional wellbeing support, based on the following guidelines:

a) There has been no new onset of COVID-19 cases in the last 14 days and the facility is not currently conducting outbreak testing;

b) Visitors should be able to adhere to the core principles and staff should provide monitoring for those who may have difficulty adhering to core principles, such as children;

c) Facilities should limit the number of visitors per resident at one time and limit the total number of visitors in the facility at one time (based on the size of the building and physical space). Facilities should consider scheduling visits for a specified length of time to help ensure all residents are able to receive visitors; and

d) Facilities should limit movement in the facility. For example, visitors should not walk around different halls of the facility. Rather, they should go directly to the resident's room or designated visitation area. Visits for residents who share a room should not be conducted in the resident's room.

e) Facilities should define a visitation space at the front of their facility for visitation to occur for residents that are mobile and not bed-bound so as not to have visitors walking throughout the facility.

f) For bed-bound residents, visitation will be held in the resident's room with an employee checking on the visit regularly to verify that all policies are being followed. The visitor will be escorted by an employee to the resident's room following symptom screening and will be escorted out once the visit has concluded.

Note: For situations where there is a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.

Facilities may also monitor other factors to understand the level of COVID-19 risk, such as rates of COVID-19-Like Illness visits to the emergency department or the positivity rate of a county adjacent to the county where the facility is located.

Note: CDC continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection, including physical distancing (maintaining at least 6 feet between people). This continues to be the safest way to prevent the spread of COVID-19, particularly if either party has not been fully vaccinated. However, we acknowledge the toll that separation and isolation has taken. We also acknowledge that there is no substitute for physical contact, such as the warm embrace between a resident and their loved one. Therefore, if the resident is fully vaccinated, they can choose to have close contact (including touch) with their visitor while wearing a well-fitting face mask and performing hand-hygiene before and after. Regardless, visitors should physically distance from other residents and staff in the facility.

Outdoor visitation

While taking a person-centered approach and adhering to the core principles of COVID-19 infection prevention, outdoor visitation is preferred even when the resident and visitor are fully vaccinated* against COVID-19. Outdoor visits generally pose a lower risk of transmission due to increased space and airflow. Therefore, all visits should be held outdoors whenever practicable. Aside from weather considerations (e.g., inclement weather, excessively hot or cold temperatures, poor air quality), an individual resident's health status (e.g., medical condition(s), COVID-19 status), or a facility's outbreak status, outdoor visitation should be facilitated routinely. Facilities should create accessible and safe outdoor spaces for visitation, such as in courtyards, patios, or parking lots, including the use of tents, if available. When

conducting outdoor visitation, facilities should have a process to limit the number and size of visits occurring simultaneously to support safe infection prevention actions (e.g., maintaining social distancing). Reasonable limits on the number of individuals visiting with any one resident at the same time should also be considered.
Note: County positivity rate does not need to be considered for outdoor visitation.

**Fully vaccinated refers to a person who is ≥2 weeks following receipt of the second dose in a 2-dose series, or ≥2 weeks following receipt of one dose of a single-dose vaccine, per the CDC's Public Health Recommendations for Vaccinated Persons.*

Family home visitation
Family member(s) should be notified of the precautions that should be taken while the resident is visiting their family and the importance of keeping the precautions in place to protect the resident and other residents, upon the resident's return to the facility, from possible exposure to COVID-19. The high risk for serious complications of COVID-19, including but not limited to death, in residential facilities for group should also be explained. The family member(s) should acknowledge their understanding of the needed precautions to maintain while the resident is out of the facility visiting with their family.

With the holidays in mind and taking a person-centered approach also while adhering to the core principles of COVID-19 infection prevention, it is important for the facility to evaluate each scenario in which a resident leaves the facility for family visitation to determine the best course of action to take upon the resident's return to the facility. Some scenarios are noted below:

> Resident and family can be trusted to follow precautions. There will only be four family members present at the family gathering and resident will not spend the night. Resident returns to facility with no additional precautions.
>
> Resident has a large family and there is a good chance that precautions will not be followed. Resident visits with 15 family members, spends the night and returns home the next day. In this case, the facility should follow the new admissions guideline of placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.

It is impossible to go over every scenario but some things to consider helping you determine the precautions to take upon a resident's return to the facility include:

- Can the resident and family be trusted to follow the necessary precautions to limit their exposure to COVID-19?
- Will the resident be out of the facility for greater than 24 hours?
- How many family members will the resident be visiting?
- Will the family be taking the resident out to a public place such as a restaurant or other event? What is the nature of the event?

Note:
Please have your visitation plan available at your facility for review by surveyors during an inspection. You are **not** required to submit your plan to HCQC for prior approval.

Screen All Staff and Visitors

1. Designate one or more facility employees to actively screen all visitors and personnel, including essential consultant personnel, for the presence of fever and symptoms of COVID-19 before starting each shift/when they enter the building. Send visitors and personnel home if they are ill or have a fever of 100.0°F or greater. Ill personnel should be prioritized for testing. Encourage or coordinate testing for COVID-19 where appropriate.

2. Staff who work in multiple locations may pose higher risks and should be asked about exposure to facilities with recognized COVID-19 cases. The risks should be weighed against the need to care for the residents.
3. Implement sick leave policies that are flexible and non-punitive.

Note: EMS personnel responding to an emergency do not need to be screened so they can attend to an emergency without delay.

Symptoms of COVID-19 may include:

- Cough
- Shortness of breath or difficulty breathing
- Fever
- Chills
- Repeated shaking with chills
- Muscle pain
- Headache
- Sore throat
- New loss of taste or smell
- Persistent pain or pressure in the chest
- New confusion or inability to wake up
- Bluish lips or face

Note: Older people with COVID-19 may not show typical symptoms such as fever or respiratory symptoms. Atypical symptoms may include new or worsening malaise, new dizziness, or diarrhea. Identification of these symptoms should prompt isolation and further evaluation for COVID-19 by the resident's physician.

Resident leaving the facility for medical and non-medical purposes

It's not recommended for residents to leave facility for non-medical purposes, below are the recommendations:
Ask residents not to leave the facility except for medically necessary purposes. Cancel all group field trips.

- **If leaving the facility for medical purpose:**
    - Residents who must regularly leave the facility for care (e.g., hemodialysis residents) should wear facemasks when outside of their rooms and maintain 6 feet's social distancing.
    - Residential facilities might consider placing residents who undergo dialysis or medical appointments in single rooms with increased monitoring given their higher risk for infection.

- **If leaving the facility for non-medical purpose:**
    - In-order to minimize the risk of COVID 19 and new variants entry to this facility the facility need to assess below conditions:
        - Each facility has to be able to do a risk assessment of each resident that plans to go out for non-medical purpose.
        - Residential facilities should educate residents and families of the risks of leaving the facility for non-medical purpose, the steps they should take to reduce the risk of contracting COVID19.
        - If the resident still wants to go out for non-medical purpose, then the recommendations would be:
            - Residents should be notified of the precautions that should be taken while the resident is outside the facility and the importance of keeping the precautions in place to protect the resident and other residents, upon the resident's return to the facility, from possible exposure to COVID-19. The high risk for serious complications

of COVID-19, including but not limited to death, in residential facilities for group should also be explained.
- The resident should acknowledge his/her understanding of the needed precautions to maintain while the resident is out of the facility non-medical purpose.
- Upon return the facility should follow residential facilities **returning residents risk assessment in Appendix C.**
- Facility should have all the above mentioned and the implemented practice added to their plan which should be educated to multidisciplinary teams.

- **If leaving the facility for family home visitation:**
  - Please refer to previously mentioned points under the family visitation point in this document.

Communal Activities and Social Distancing

Additionally, group activities may also be facilitated (for residents who have fully recovered from COVID-19, and for those not in isolation for observation, or with suspected or confirmed COVID-19 status) with social distancing among residents, appropriate hand hygiene, and use of a face covering. Facilities may be able to offer a variety of activities while also taking necessary precautions. For example, book clubs, crafts, movies, exercise, and bingo are all activities that can be facilitated with alterations to adhere to the guidelines for preventing transmission.

Maintaining a good social distance (at least 6 feet) is very important in preventing the spread of COVID-19.
The following preventative measures should be considered:

- Arrange seating of chairs and tables to be least 6 feet (2 meters) apart during shared meals or other events.
- Alter schedules to reduce mixing and close contact, such as staggering meal and activity times and forming small groups that regularly participate at the same times and do not mix.
- Ensure that social distancing can be maintained in shared rooms, such as television, game, or exercise rooms.
- Make sure that shared rooms in the facility have good air flow from an air conditioner or an opened window.
- Consider working with building maintenance staff to determine if the building ventilation system can be modified to increase ventilation rates. Improving ventilation helps remove respiratory droplets from the air.
- If possible, residents should have their own room and bathroom.

Note: Facilities should consider additional limitations based on status of COVID-19 infections in the facility, for example, if the facility is experiencing an outbreak the facility should consider temporarily canceling all non-essential group activities and events, until such time that the outbreak is fully contained. Guidance on when to restart communal activities should be obtained from the Division of Public and Behavioral Health's Office of Public Health Investigations and Epidemiology at DPBHHAI@health.nv.gov or The Bureau of Health Care Quality and Compliance at pbhlicensing@health.nv.gov.

Considerations for specific communal rooms in your facility

Shared kitchens and dining rooms

While adhering to the core principles of COVID-19 infection prevention, communal dining may occur. While residents are eating in the same room the following guidelines should be followed:

- Restrict the number of people allowed in the kitchen and dining room at one time so that everyone can stay at least 6 feet (2 meters) apart from one another.
  - People who are sick, their roommates, and those who have higher risk of severe illness from COVID-19 should eat or be fed in their room.
- Do not share dishes, drinking glasses, cups, or eating utensils. Non-disposable food service items used should be handled with gloves and washed with dish soap and hot water or in a dishwasher. Wash hands after handling used food service items.
- Use gloves when removing garbage bags and handling and disposing of trash. Wash hands.

- All kitchen and dining room staff must be trained to the policies and procedures for infection control and prevention in the dining rooms including but not limited to cleaning and disinfecting between meal services.

Note: Facilities should consider additional limitations based on status of COVID-19 infections in the facility, for example, if the facility is experiencing an outbreak the facility should consider temporarily closing the communal dining area and serving residents in their individual rooms.

Laundry rooms

- Maintain access and adequate supplies to laundry facilities to help prevent spread of COVID-19.
- Restrict the number of people allowed in laundry rooms at one time to ensure everyone can stay at least 6 feet (2 meters) apart.
- Provide disposable gloves, soap for washing hands, and household cleaners and EPA-registered disinfectants (https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2-covid-19) for residents and staff to clean and disinfect buttons, knobs, and handles of laundry machines, laundry baskets, and shared laundry items.
- Post guidelines for doing laundry such as washing instructions and handling of dirty laundry. For example, the laundry of COVID-19 positive residents should be washed in the hottest tolerable water and dried at the highest temperature tolerated as well. (http://nsla.nv.gov/ld.php?content_id=54777857 page 2 of 3)

Recreational areas such as activity rooms and exercise rooms

- Consider closing activity rooms or restricting the number of people allowed in at one time to ensure everyone can stay at least 6 feet (2 meters) apart.
- Consider closing exercise rooms.
- Activities and sports (e.g., ping pong, basketball, chess) that require close contact are not recommended.

Pools and hot tubs

- Consider closing pools and hot tubs or limiting access to pools for essential activities only, such as water therapy.
    - While proper operation, maintenance, and disinfection (with chlorine or bromine) should kill COVID-19 in pools and hot tubs, they may become crowded and could easily exceed recommended guidance for gatherings. It can also be challenging to keep surfaces clean and disinfected.
    - Considerations for shared spaces (maintaining physical distance and cleaning and disinfecting surfaces) should be addressed for the pool and hot tub area and in locker rooms if they remain open.

Shared bathrooms

- Shared bathrooms should be cleaned regularly using EPA-registered disinfectants at least twice per day (e.g., in the morning and evening and after times of heavy use).
- Make sure bathrooms are continuously stocked with soap and paper towels or automated hand dryers. Hand sanitizer could also be made available.
- Make sure trash cans are emptied regularly.
- Provide information on how to wash hands properly. Hang hand hygiene signs (https://www.cdc.gov/handwashing/posters.html) in bathrooms.
- Residents should be instructed that sinks could be an infection source and should avoid placing toothbrushes directly on counter surfaces. Totes could also be used for personal items to limit their contact with other surfaces in the bathroom.

Rapidly identify and properly respond to residents with suspected or confirmed COVID-19

1. Designate one or more facility employees to ensure all residents have been asked at least daily about fever and symptoms of COVID-19 (e.g., sore throat, new or worsening cough, shortness of breath, muscle aches, new loss of taste or smell and others listed in Symptoms of COVID-19 section).

2. Implement a process or facility point of contact whom residents can notify (e.g., call by phone) if they develop symptoms.
3. If COVID-19 is identified or suspected in a resident (i.e. resident reports fever or symptoms of COVID-19), immediately isolate the resident in their room and notify the resident's physician and health department.
4. Identify space in the facility that could be dedicated to care for residents with confirmed COVID-19. This could be a dedicated floor, unit, or wing in the facility or a group of rooms at the end of the unit that will be used to cohort residents with COVID-19.

- Identify caregivers who will be assigned to work only on the COVID-19 care unit when it is in use.
- Have a plan for how residents in the facility who develop COVID-19 will be handled (e.g., transfer to single room, implement use of Transmission-Based Precautions, prioritize for testing, transfer to COVID-19 unit if positive).
- Residents in the facility who develop symptoms consistent with COVID-19 could be moved to a single room pending results of SARS-CoV-2 testing. They should not be placed in a room with a new admission nor should they be moved to the COVID-19 care unit unless they are confirmed to have COVID-19 by testing. While awaiting results of testing, caregivers should wear an N95 or higher-level respirator (or facemask if a respirator is not available), eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face), gloves, and gown when caring for these residents. Cloth face coverings are not considered PPE and should only be worn by caregivers for source control, not when PPE is indicated.
- Have a plan for how roommates, other residents, and caregivers who may have been exposed to an individual with COVID-19 will be handled (e.g., monitor closely, avoid placing unexposed residents into a shared space with them).

5. An ill resident might be able to remain in the facility if the resident:
    - Can isolate in their room for the duration of their illness
    - Can have meals delivered – Use disposable food utensils, containers, cups, forks, etc. and discard in dedicated marked COVID trash bag. Remove unnecessary shared items.
    - There is a mechanism for staff to regularly check on the resident; visits by home health agency personnel who wear all recommended PPE
    - Is able to request assistance.

It might also be possible for ill residents who require more assistance to remain in the facility if they can remain isolated in their room, and on-site or consultant personnel can provide the level of care needed with access to all recommended PPE and training on proper selection and use.

If the ill resident requires more assistance than can be safely provided by on-site or consultant personnel (e.g., home health agency), they should be transferred (in consultation with public health) to another location (e.g., alternate care site, hospital) that is equipped to adhere to recommended infection prevention and control practices. Transport personnel and the receiving facility should be notified about the suspected diagnosis prior to transfer.

- While awaiting transfer, symptomatic residents should wear a cloth face covering (if tolerated) and be separated from others (e.g., kept in their room with the door closed). Appropriate PPE, as described above, should be used by caregivers when coming in contact with the resident.

- If residents are transferred to the hospital or another care setting, actively follow up with that facility and resident family members to determine if the resident was known or suspected to have COVID-19. This information will inform the need for contact tracing or implementation of additional infection prevention practices recommendations.
    - Implement processes to maintain social distancing (remaining at least 6 feet apart) between all residents and personnel while still providing necessary services.

- If a resident is experiencing a medical emergency such as persistent pain or pressure in the chest, new confusion or inability to wake up, bluish lips or face, or difficulty breathing, call 911 and tell the dispatcher that the resident has or might have COVID-19.
  The items listed above are not the only reason to call 911. Call 911 for any and all medical emergencies a resident may be experiencing.

New admissions or readmissions with an unknown COVID-19 status

Depending on the prevalence of COVID-19 in the community, this might include placing the resident in a single-person room or in a separate observation area so the resident can be monitored for evidence of COVID-19. Residents can be transferred out of the observation area to the main facility if they remain afebrile and without symptoms for 14 days after their admission.

The Division of Public and Behavioral Health is recommending that all new admissions and readmissions, regardless of vaccination status, follow the CDC's quarantine guidelines for unvaccinated residents by placing all new admissions and readmissions on a 14-day quarantine period, even if the individual initially had a negative COVID-19 test. However, based on local circumstances and the availability of adequate testing resources, the following options to shorten quarantine can be acceptable alternatives:

- Quarantine can end after Day 10 without testing if no symptoms have been reported during daily monitoring.
- When testing resources are available, quarantine can end after Day 7 if a diagnostic specimen tests negative and no symptoms were reported during daily monitoring. The specimen should be collected and tested within 48 hours before the time of planned quarantine discontinuation (in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.
  In both options, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met. Full information on this issue can be found in the technical bulletin, titled, *Quarantine new admits and readmissions regardless of vaccination status in nursing homes and residential facilities*, on the Division of Public and Behavioral Health website.

Resident/family notification

Inform residents, their representatives, and families of those residing in facilities by 5:00 P.M. the next calendar day following the occurrence of either a single confirmed infection of COVID-19, or two or more residents or staff with new-onset of respiratory symptoms occurring within 72 hours of each other. This information must—

(i) Not include personally identifiable information;

(ii) Include information on actions to prevent or reduce the risk of transmission, including if normal operations of the facility will be altered; and

(iii) Include any cumulative updates for residents, their representatives, and families at least weekly or by 5 p.m. the next calendar day following the subsequent occurrence of either. Each time a confirmed infection of COVID-19 is identified, or whenever three or more residents or staff with new onset of respiratory symptoms occur within 72 hours of each other.

Local health department notification

Notify your local health department if:

- COVID-19 is suspected or confirmed among residents or facility personnel
- A resident develops severe respiratory infection
- More than two residents or facility personnel develop fever or respiratory symptoms within 72 hours of each other.

Nevada Division of Public and Behavioral Health

- 24-hour phone: (775) 684-5911
- http://dpbh.nv.gov/

Carson City Health & Human Services
- Business hours: (775) 887-2190
- After hours: (775) 887-2190
- https://gethealthycarsoncity.org/

Southern Nevada Health District
- 24-hour phone: (702) 759-1300
- https://www.southernnevadahealthdistrict.org/

Washoe County Health District
- 24-hour phone: (775) 328-2447
- https://washoecounty.us/health/

Testing

- If a staff member or resident is suspected of having COVID-19 consult with your health authority about having the staff member or resident tested.
- If one or more staff members or residents test positive for COVID-19, contact your health authority for consideration of facility wide testing for all residents and staff members.
    - If staff member refuses testing, consider implementing a policy requiring staff member to be tested prior to returning to work.
    - If resident refuses testing, explain to resident the importance of testing and how it can help protect the resident and others in the facility. If the resident continues to refuse, document refusal to be tested in resident's file.

Visitor testing and vaccination

We encourage facilities in medium- or high-positivity counties to offer testing to visitors, if feasible. If so, facilities should prioritize visitors that visit regularly (e.g., weekly), although any visitor can be tested. Facilities may also encourage visitors to be tested on their own prior to coming to the facility (e.g., within 2-3 days). Similarly, we encourage visitors to become vaccinated when they have the opportunity. While visitor testing and vaccination can help prevent the spread of COVID-19, visitors should not be required to be tested or vaccinated (or show proof of such) as a condition of visitation. This also applies to representatives of the Office of the State Long-Term Care Ombudsman and protection and advocacy systems, as described below.

Tracking residents and staff during a suspected respiratory illness cluster/outbreak

The Respiratory Surveillance Line List provides a template for data collection and active monitoring of both residents and staff during a suspected respiratory illness cluster or outbreak. This template was developed to help with data collection for common respiratory illness outbreaks. The data fields can be modified to reflect the needs of the individual facility during other outbreaks. Information gathered on the worksheet should be used to build a case definition, determine the duration of outbreak illness, support monitoring for and rapid identification of new cases, and assist with implementation of infection control measures by identifying units where cases are occurring.

Respiratory Surveillance Line List:
https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf

Duration/Discontinuation of Isolation and Precautions for Adults with COVID-19
https://www.cdc.gov/coronavirus/2019-ncov/hcp/duration-isolation.html

Recommendations for duration of isolation and precautions

Symptoms-based strategy:

Residents with mild to moderate illness who are not severely immunocompromised:

- At least 10 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved

Residents who were asymptomatic throughout their infection and are not severely immunocompromised:

- At least 10 days have passed since the date of their first positive viral diagnostic test.

Residents with severe to critical illness or who are severely immunocompromised:

- At least 10 days and up to 20 days have passed *since symptoms first appeared* **and**
- At least 24 hours have passed *since last* fever without the use of fever-reducing medications **and**
- Symptoms (e.g., cough, shortness of breath) have improved
- Consider consultation with infection control experts

Residents who are **severely immunocompromised** may produce replication-competent virus beyond 20 days after symptom onset or, for those who were asymptomatic throughout their infection, the date of their first positive viral test. Consultation with infectious diseases specialists is recommended. Use of a test-based strategy for determining when transmission-based precautions may be discontinued could be considered.

Test-based strategy:

Role of PCR testing (a COVID-19 diagnostic test) to discontinue isolation or precautions

- For persons who are severely immunocompromised, a test-based strategy could be considered in consultation with infectious diseases experts.
- For all others, a test-based strategy is no longer recommended except to discontinue isolation or precautions earlier than would occur under the strategy outlined in Part 1, above.

For more information refer to the CDC's Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 in Health care Settings (Interim Guidance). Found at: https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-residents.html

Role of PCR testing (a COVID-19 diagnostic test) after discontinuation of isolation or precautions

- For persons previously diagnosed with symptomatic COVID-19 who remain asymptomatic after recovery, retesting is not recommended within three months after the date of symptom onset for the initial COVID-19 infection.
- For persons who develop new symptoms consistent with COVID-19 during the three months after the date of initial symptom onset, if an alternative etiology cannot be identified by a provider, then the person may warrant retesting; consultation with infectious disease or infection control experts is recommended. Isolation may be considered during this evaluation based on consultation with an infection control expert, especially in the event symptoms develop within 14 days after close contact with an infected person.
- For persons who never developed symptoms, the date of first positive RT-PCR test for SARS-CoV-2 RNA (a COVID-19 Diagnostic Test) should be used in place of the date of symptom onset.

Role of serologic testing

- Serologic testing should not be used to establish the presence or absence of SARS-CoV-2 infection or reinfection.

Monitor and plan for absenteeism among staff

- Develop plans to cover activities in the event of increased staff absences. Coordinate with other local residential facility for groups and reach out to substitutes to determine their anticipated availability if regular staff members need to stay home if they or their family members are sick.

Require sick staff to stay home.

- Communicate to staff the importance of staying home when they are sick.
- Communicate to staff the importance of being vigilant for symptoms and staying in touch with facility management if or when they start to feel sick.
- Sick staff members should not return to work until they have met the criteria for Discontinuation of Isolation and Precautions for Adults with COVID-19 (please refer to CDC link https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html)

Strategies to mitigate staffing shortages

Maintaining appropriate staffing in facilities is essential to providing a safe work environment for staff and safe resident care. As the COVID-19 pandemic progresses, staffing shortages will likely occur due to staff exposures, illness, or need to care for family members at home. Facilities must be prepared for staffing shortages and plan accordingly. Considerations for creating a staffing contingency plan include (but are not limited to):

- Not admitting new residents until staffing shortages are alleviated
- Staffing agency
- Management or office staff to assist with residents (within their scope of practice)
- Implement sick leave policies that are flexible and non-punitive
- Bonus or overtime pay
- Closing the facility (may be an option for smaller facilities)

Other strategies could be found in: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html

Educate residents, family members, and personnel about COVID-19

- Have a plan and mechanism to regularly communicate with personnel, residents, and any family members specified by the resident.
- Provide information about COVID-19 (including information about signs and symptoms) and strategies for managing stress and anxiety.
- Describe actions the facility is taking to protect residents and personnel.
- Describe actions residents and personnel can take to protect themselves in the facility, emphasizing the importance of social (physical) distancing, hand hygiene, respiratory hygiene and cough etiquette, and face mask or alternate face covering source control (keeps respiratory droplets contained and from reaching other people).
- Remind residents and visitors that public health authorities have urged older adults and people of any age who have serious underlying medical conditions to remain home and limit their interactions with others.
- If residents leave their room or are around others, they should wear a cloth face covering (if tolerated), regardless of symptoms. If the resident does not have a cloth face cover, a facemask may be used for source control if supplies allow.
- Encourage residents, personnel, and visitors to remain vigilant for and immediately report fever or symptoms consistent with COVID-19 (e.g., sore throat, new or worsening cough, shortness of breath, muscle aches). Ask visitors to inform the facility if they develop fever or symptoms consistent with COVID-19 within 14 days of visiting the facility.

Note: Cloth face coverings should not be worn or placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance. Additionally, they should not be placed on children under age 2.

Prevention

COVID-19 vaccine: Continue your efforts to sign up residents and staff for COVID-19 vaccination. Complete the Nevada COVID-19 Interest form located at https://dpbhrdc.nv.gov/redcap/surveys/?s=N7ACTF4CYL.
Additional information regarding the COVID-19 vaccine can be found at dpbh.nv.gov/Programs/Immunization/COVID/COVID_Vaccine/

Flu shots - It is important that all residents receive the quadrivalent inactivated influenza vaccine unless there is a medical contraindication or the resident or legal representative refuses. Vaccines should be given before flu season starts if possible.

Pneumococcal vaccination – The CDC recommends the pneumococcal vaccination for all adults 65 years or older. Pneumococcal disease in older adults may place them at risk for serious illness and death.

Shingles vaccination is the only way to protect against shingles and postherpetic neuralgia (PHN), the most common complication from shingles. CDC recommends that healthy adults 50 years and older get two doses of the shingles vaccine called Shingrix (recombinant zoster vaccine), separated by two to six months, to prevent shingles and the complications from the disease. Two doses of Shingrix is more than 90% effective at preventing shingles and PHN. Protection stays above 85% for at least the first four years after you get vaccinated.

Discuss these four important vaccinations with residents and their physicians.

Hand hygiene

1) The facility should ensure that hand hygiene supplies are readily available to all personnel in every care location.
2) Wash your hands often with soap and water for at least 20 seconds. Tell everyone in the home to do the same, especially after being near the person who is sick.
3) Hand sanitizer: If soap and water are not readily available, use a hand sanitizer that contains at least 60% alcohol. Cover all surfaces of your hands and rub them together until they feel dry. If hands are visibly soiled, use soap and water before returning to an alcohol-based hand sanitizer.
4) Hands off: Avoid touching your eyes, nose, and mouth with unwashed hands.

Handwashing should be done on the following occasions:

- Before, during, and after preparing food
- Before eating food
- Before and after providing care to a resident
- Before and after caring for someone at home who is sick with vomiting or diarrhea
- Before and after treating a cut or wound
- After using the toilet
- After changing incontinence briefs or cleaning up a resident who has used the toilet
- After blowing your nose, coughing, or sneezing
- After touching an animal, animal feed, or animal waste
- After handling pet food or pet treats
- After touching garbage
- After contact with potentially infectious material,
- Before putting on and after removing PPE, including gloves. Hand hygiene after removing PPE is particularly important to remove any pathogens that might have been transferred to bare hands during the removal process.

During the COVID-19 pandemic, handwashing should also be performed on the following occasions:

- After having been in a public place and touching an item or surface that may be frequently touched by other people, such as door handles, tables, gas pumps, shopping carts or electronic cashier registers/screens, etc.
- Before touching eyes, nose or mouth because that is how germs enter the body.

Five steps in handwashing

- Wet hands with clean, running water (warm or cold), turn off the tap, and apply soap. Hand washing posters can be found here: https://www.cdc.gov/handwashing/posters.html.
- Lather hands by rubbing them together with the soap. Lather the backs of hands, between fingers, and under the nails.
- Scrub hands for at least 20 seconds. Need a timer? Hum the "Happy Birthday" song from beginning to end twice.
- Rinse hands well under clean, running water.
- Dry hands using a clean towel or air dry them.
- Turn off the tap water with a disposable towel to avoid re-contaminating your hands again.

Sanitizers can quickly reduce the number of germs on hands in many situations, however:

- Sanitizers do not get rid of all types of germs.
- Hand sanitizers may not be as effective when hands are visibly dirty or greasy.
- Hand sanitizers might not remove harmful chemicals from hands like pesticides and heavy metals.

How to use hand sanitizer

- Apply the gel product to the palm of one hand (read the label to learn the correct amount).
- Rub hands together.
- Rub the gel over all the surfaces of the hands and fingers until the hands are dry. This should take around 20 seconds.

Open the following link to access the video on handwashing:
https://www.cdc.gov/handwashing/

Personal protective equipment (PPE)

Generical PPE considerations:

- Universal masking source control measures:
  - **Caregivers should wear a well-fitting* facemask at all times while they are in the facility.**
  - Well-fitting facemasks are generally preferred for HCP as facemasks offer both source control and protection for the wearer against exposure to splashes and sprays of infectious material from others. Facility should follow their internal policy on extended use and reuse of facemasks. Cloth face coverings should NOT be worn by HCP instead of a respirator or facemask and they are not considered a personal protective equipment (PPE) appropriate for use by health care personnel.
  - Residents should wear a well-fitting* cloth face covering or facemask (if tolerated) whenever they leave their room, including for procedures outside the facility.
    - Cloth face coverings should not be placed on anyone who has trouble breathing, or anyone who is unconscious, incapacitated, or otherwise unable to remove the mask without assistance.
    - In addition to the categories described above cloth face coverings should not be placed on children under 2.
  - Visitors, if permitted into the facility, should wear a well-fitting* cloth face covering while in the facility, Visitors who are not able to wear source control should be encouraged to use alternatives to on-site visits with residents (e.g., telephone or internet communication), particularly if the resident is at increased risk for severe illness from SARS-CoV-2 infection.

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***Note:** A well-fitting facemask should have no air flow from the area near the eyes or from the sides of the mask; proper efficacy could be achieved with below optional methods:

- Selection of a facemask with a nose wire to help the facemask conform to the face.
- Selection of a facemask with ties rather than ear loops.
- Use of a mask fitter or brace may also help to improve fit.
- Tying the facemask's ear loops and tucking in the side pleats.

For further information, refer to CDC link: https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/mask-fit-and-filtration.html

Specific PPE considerations:

Implement universal use of PPE for caregivers

If SARS-CoV-2 infection is not suspected in a resident presenting for care (based on symptom and exposure history), caregivers working in facilities located in counties with substantial or high transmission should also use PPE as described below. This link is to be used when selecting PPE for use if SARS-CoV-2 infection is **not** suspected in a resident presenting for care https://covid.cdc.gov/covid-data-tracker/#county-view

- NIOSH-approved N95 or equivalent or higher-level respirators should be used for:
    - All aerosol-generating procedures (refer to Which procedures are considered aerosol generating procedures in health care settings?)
- Facilities could consider use of NIOSH-approved N95 or equivalent or higher-level respirators for caregivers working in other situations where multiple risk factors for transmission are present. One example might be if the resident is unvaccinated, unable to use source control, and the area is poorly ventilated.
- Eye protection (i.e., goggles or a face shield that covers the front and sides of the face) should be worn during all resident care encounters.
  Infection Control: Severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) | CDC

Caregivers providing care to residents with suspected COVID-19 (resident reports fever, shortness of breath or other symptoms consistent with COVID-19) or who are COVID-19 positive (both residents with symptoms and without symptoms) should, at a minimum, wear:

- Eye protection (goggles or face shield) and an N95 or higher-level respirator. **Face coverings are not PPE and should not be used when a respirator or facemask is indicated.**
- Gown and gloves

*The below recommendations are to be followed for crisis situations when no other NIOSH- approved N95 respirators are available:

- **Scenario 1: Facility only has KN95 masks and has proof of attempt to attain N95 masks.** In this scenario, the CDC guidance allows the next step down for PPE (mask, gown, gloves, and face shield). The mask is the real difference. The CDC states a step-down mask such as a surgical mask be utilized, since the facility has KN95's, they could be utilized as well. If KN95's are used, it is suggested the individual also wear a surgical mask over the top. A KN95 is not considered a full protective barrier like a fitted N95. With KN95's, it is unknown what filtering guidelines have been met. We know that the surgical masks have been cleared to a certain level. We would not suggest a KN95 be worn alone though.
- **Scenario 2: Facility has the available PPE (mask, gown, gloves, and face shield) – Use of surgical mask as an alternative to fitted N95 respirator mask.** Personnel who do not interact with residents (e.g., not within 6 feet) and do not clean resident environments or equipment do not need to wear PPE. Consistent with the guidance for the general public, however, they should wear a cloth face covering for source control.

Personnel who are expected to use PPE should receive training on selection and use of PPE, including demonstrating competency with putting on and removing PPE in a manner to prevent self-contamination.

CDC has provided PPE supply that describe actions facilities can take to extend their supply if, despite efforts to obtain additional PPE, there are shortages. These include strategies such as extended use or reuse of respirators, facemasks, and disposable eye protection.

IMPORTANT: If using PPE extended use/optimizing strategies the facility should have a policy and procedure in place, based on CDC guidelines. Please see resource guide for links.

All caregivers must receive training on and demonstrate an understanding of:

- when to use PPE
- what PPE is necessary
- how to properly put on, use, and take off PPE in a manner to prevent self-contamination
- how to properly dispose of or disinfect and maintain PPE
- the limitations of PPE.

Any reusable PPE must be properly cleaned, decontaminated, and maintained after and between uses in accordance with the manufacturer's instructions. The PPE recommended when caring for a resident(s) with known or suspected COVID-19 includes:

- Respirator or facemask (cloth face coverings are NOT PPE and should not be worn for the care of residents with known or suspected COVID-19 or other situations where a respirator or facemask is warranted)
  - If the facility has any case of COVID-19 put on an N95 respirator (or higher-level respirator) or facemask (if a respirator is not available) before entry into ALL resident rooms or care areas, even those that do not have COVID-19.
  - Disposable respirators and facemasks should be removed and discarded after exiting a resident's room or care area and closing the door unless implementing extended use or reuse. Perform hand hygiene after removing the respirator or facemask.
    - If reusable respirators (e.g., powered air-purifying respirators [PAPRs]) are used, they must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use.
  - When the supply chain is restored, facilities with a respiratory protection program should return to use of respirators for residents with known or suspected COVID-19. Those that do not currently have a respiratory protection program, but care for residents with pathogens for which a respirator is recommended, should implement a respiratory protection program. Components of a respiratory protection program include but are not limited to:
    - Documented Respiratory Protection Plan
    - Respiratory Protection Program Administrator
    - Staff Medical Evaluation & Respirator Test Fitting
    - Staff training program

OSHA Respiratory Protection Program Guidelines: https://www.osha.gov/enforcement/directives/cpl-02-02-054

- Eye protection
  - Put on eye protection (i.e., goggles or a disposable face shield that covers the front and sides of the face) upon entry to the resident room or care area, if not already wearing as part of extended use or reuse strategies to optimize PPE supply. Personal eyeglasses and contact lenses are ***not*** considered adequate eye protection.
  - Remove eye protection after or when leaving the resident room or care area.

    - Reusable eye protection (e.g., goggles) must be cleaned and disinfected according to manufacturer's reprocessing instructions prior to re-use. Disposable eye protection should be discarded after use unless following protocols for extended use or reuse.
- Gloves
    - Put on clean, non-sterile gloves upon entry into the resident room or care area.
        - Change gloves if they become torn or heavily contaminated.
    - Remove and discard gloves when leaving the resident room or care area, and immediately perform hand hygiene.

- Gowns
    - Put on a clean isolation gown upon entry into the resident room or area. Change the gown if it becomes soiled. Remove and discard the gown in a dedicated container for waste or linen before leaving the resident room or care area. Disposable gowns should be discarded after use. Cloth gowns should be laundered after each use.
    - If there are shortages of gowns, they should be prioritized for:
        - aerosol generating procedures
        - care activities where splashes and sprays are anticipated
        - high-contact resident care activities that provide opportunities for transfer of pathogens to the hands and clothing of caregivers. Examples include:
            - dressing
            - bathing/showering
            - transferring
            - providing hygiene
            - changing linens
            - changing briefs or assisting with toileting
            - device care or use
            - wound care
    - Additional strategies for optimizing supply of gowns are available.
- Obtain a relationship/contract with a PPE vendor, track use of PPE and order before you run out. It is imperative that your facility has enough PPE to prevent the spread of COVID-19.

Open the following link to access the strategies to optimize the supply of PPE and equipment:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html

How to put on (con) PPE:
More than one donning method may be acceptable. Training and practice using the facility's procedure is critical. Below is one example of donning.

a. Identify and gather the proper PPE to don. Ensure choice of gown size is correct.
b. Perform hand hygiene using hand sanitizer.
c. Put on isolation gown. Tie all the ties on the gown. Assistance may be needed by other health care personnel.
d. Put on NIOSH-approved N95 filtering facepiece respirator or higher (use a facemask if a respirator is not available). If the respirator has a nosepiece, it should be fitted to the nose with both hands, not bent or tented. Do not pinch the nosepiece with one hand. Respirator/facemask should be extended under chin. Both the mouth and nose should be protected. Do not wear respirator/facemask under the chin or store in scrubs pocket between residents. *
    - Respirator: Respirator straps should be placed on crown of head (top strap) and base of neck (bottom strap). Perform a user seal check each time you put on the respirator.
    - Facemask: Mask ties should be secured on crown of head (top tie) and base of neck (bottom tie). If mask has loops, hook them appropriately around the ears.

e. Put on face shield or goggles. Face shields provide full face coverage. Goggles also provide excellent protection for eyes, but fogging is common.
f. Perform hand hygiene before putting on gloves. Gloves should cover the cuff (wrist) of gown.
g. Health care personnel/caregivers may now enter the resident room.

How to take off (doff) PPE:

More than one doffing method may be acceptable. Training and practice using the facility's procedure is critical. Below is one example of doffing.

a. Remove gloves. Ensure glove removal does not cause additional contamination of hands. Gloves can be removed using more than one technique (e.g., glove-in-glove or bird beak).
b. Remove gown. Untie all ties (or unsnap all buttons). Some gown ties can be broken rather than untied. Do so in gentle manner, avoiding a forceful movement. Reach up to the shoulders and carefully pull gown down and away from the body. Rolling the gown down is an acceptable approach. Dispose in trash receptacle. *
c. Health care personnel/caregivers may now exit the resident room.
d. Perform hand hygiene.
e. Remove face shield or goggles. Carefully remove face shield or goggles by grabbing the strap and pulling upwards and away from head. Do not touch the front of face shield or goggles.
f. Remove and discard respirator (or facemask if used instead of respirator). Do not touch the front of the respirator or facemask. *
    - Respirator: Remove the bottom strap by touching only the strap and bring it carefully over the head. Grasp the top strap and bring it carefully over the head, and then pull the respirator away from the face without touching the front of the respirator.
    - Facemask: Carefully untie (or unhook from the ears) and pull away from face without touching the front.
g. Perform hand hygiene after removing the respirator/facemask and before putting it on again if your workplace is practicing reuse. *

** Facilities implementing reuse or extended use of PPE will need to adjust their donning (putting on) PPE and doffing (removing) PPE procedures to accommodate those practices.*

Open the following link to access the video on how to safely put on PPE:
https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

Cleaning and disinfection of facility

a. Clean and disinfect "high-touch" surfaces and items every day: This includes tables, doorknobs, light switches, handles, desks, toilets, faucets, sinks, and electronics.
b. Clean the area or item with soap and water if it is dirty. Then, use a household disinfectant.
    - Be sure to follow the instructions on the label to ensure safe and effective use of the product. Many products recommend keeping the surface wet for several minutes to kill germs. Many also recommend wearing gloves, making sure you have good air flow, and wiping or rinsing off the product after use.
    - Use EPA- registered disinfectants to clean.
    - To clean electronics, follow the manufacturer's instructions for all cleaning and disinfection products. If those directions are not available, use alcohol-based wipes or spray containing at least 70% alcohol.

Open the following link to access the list of EPA-registered disinfectants:
https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

Bedroom and bathroom:

a. If you are using a separate bedroom and bathroom: Only clean the area around the person who is sick when needed, such as when the area is soiled. This will help limit your contact with the sick person.

b. If sharing a bathroom: The person who is sick should clean and then disinfect after each use. If this is not possible, wear a mask and wait as long as possible after the sick person has used the bathroom before coming in to clean and use the bathroom.

Wash and dry laundry:

a. Do not shake dirty laundry.
b. Wear disposable gloves while handling dirty laundry.
c. Dirty laundry from a person who is sick can be washed with other people's items.
d. Wash items according to the label instructions. Use the warmest water setting you can.
e. Remove gloves, and wash hands right away.
f. Dry laundry, on hot if possible, completely.
g. Wash hands after putting clothes in the dryer.
h. Clean and disinfect clothes hampers. Wash hands afterwards.

Use lined trash can:

a. Place used disposable gloves and other contaminated items in a lined trash can.
b. Use gloves when removing garbage bags, and handling and disposing of trash. Wash hands afterwards.
c. Place all used disposable gloves, facemasks, and other contaminated items in a lined trash can.
d. If possible, dedicate a lined trash can for the person who is sick.

Cleaning and disinfection after persons suspected/confirmed to have COVID-19 have been in the facility

Timing and location of cleaning and disinfection of surfaces

Close off areas visited by the ill persons. Open outside doors and windows and use ventilating fans to increase air circulation in the area. Wait 24 hours or as long as practical before beginning cleaning and disinfection.

Cleaning staff should clean and disinfect all areas such as offices, bathrooms, common areas, shared electronic equipment (like tablets, touch screens, keyboards, remote controls, and ATM machines) used by the ill persons, focusing especially on frequently touched surfaces**.**

How to clean and disinfect:

Hard (non-porous) surfaces

- Wear disposable gloves when cleaning and disinfecting surfaces. Gloves should be discarded after each cleaning. If reusable gloves are used, those gloves should be dedicated for cleaning and disinfection of surfaces for COVID-19 and should not be used for other purposes. Consult the manufacturer's instructions for cleaning and disinfection products used. Clean hands immediately after gloves are removed.
- If surfaces are dirty, they should be cleaned using a detergent or soap and water prior to disinfection.
  Always read and follow the directions on the label to ensure safe and effective use.
- Wear skin protection and consider eye protection for potential splash hazards
- Ensure adequate ventilation
- Use no more than the amount recommended on the label
- Use water at room temperature for dilution (unless stated otherwise on the label)
- Avoid mixing chemical products
- Label diluted cleaning solutions
- Store and use chemicals out of the reach of children and pets

You should never eat, drink, breathe or inject these products into your body or apply directly to your skin as they can cause serious harm. Do not wipe or bathe pets with these products or any other products that are not approved for animal use.

See EPA's 6 steps for Safe and Effective Disinfectant Use by going to: https://www.epa.gov/sites/production/files/2020-04/documents/disinfectants-onepager.pdf

Special considerations should be made for people with asthma and they should not be present when cleaning and disinfecting is happening as this can trigger asthma exacerbations.

- Disinfect with a household disinfectant on the EPA's List N to kill COVID-19 found at: https://www.epa.gov/pesticide-registration/list-n-disinfectants-coronavirus-covid-19 Follow the manufacturer's instructions for all cleaning and disinfection products. Read the product label for the correct concentration to use, application method, and contact time.
- Diluted household bleach solutions can be used if appropriate for the surface. Unexpired household bleach will be effective against coronaviruses when properly diluted:
    - Use bleach containing 5.25%-8.25% sodium hypochlorite. Do not use a bleach product if the percentage is not in this range or is not specified.
    - Follow the manufacturer's application instructions for the surface, ensuring a contact time of at least 1 minute.
    - Ensure proper ventilation during and after application.
    - Check to ensure the product is not past its expiration date.
    - Never mix household bleach with ammonia or any other cleanser. This can cause fumes that may be very dangerous to breathe in.
- Prepare a bleach solution by mixing:
    - 5 tablespoons (1/3 cup) of 5.25%-8.25% bleach per gallon of room temperature water, or
    - 4 teaspoons of 5.25%-8.25% bleach per quart of room temperature water
- Bleach solutions will be effective for disinfection up to 24 hours.
- Alcohol solutions with at least 70% alcohol may also be used.
- Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Always read and follow the directions on the label to ensure safe and effective use.
- Keep hand sanitizers away from fire or flame
- For children under 6 years of age, hand sanitizer should be used with adult supervision
- Always store hand sanitizer out of reach of children and pets
- Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands.
    - Additional key times to clean hands include:
        - After blowing one's nose, coughing, or sneezing.
        - After using the restroom.
        - Before eating or preparing food.
        - After contact with animals or pets.
        - Before and after providing routine care for another person who needs assistance such as a child.

Soft (porous) surfaces such as carpeted floor, rugs and drapes: remove visible contamination if present and clean with appropriate cleaners indicated for use on these surfaces. After cleaning:

- If the items can be laundered, launder items in accordance with the manufacturer's instructions using the warmest appropriate water setting for the items and then dry items completely.
    - Otherwise, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces

Electronics such as tablets, touch screens, keyboards, remote controls, and ATM machines: remove visible contamination if present.

- Follow the manufacturer's instructions for all cleaning and disinfection products.
- Consider use of wipeable covers for electronics.

- If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect touch screens. Dry surfaces thoroughly to avoid pooling of liquids.

Linens, clothing and other items that go in the laundry

- In order to minimize the possibility of dispersing virus through the air, do not shake dirty laundry.
- Wash items as appropriate in accordance with the manufacturer's instructions. If possible, launder items using the warmest appropriate water setting for the items and dry items completely. Dirty laundry that has been in contact with an ill person can be washed with other people's items.
- Clean and disinfect hampers or other carts for transporting laundry according to guidance above for hard or soft surfaces.

The risk of exposure to cleaning staff is inherently low. Cleaning staff should wear disposable gloves and gowns for all tasks in the cleaning process, including handling trash.

- Gloves and gowns should be compatible with the disinfectant products being used.
- Additional PPE might be required based on the cleaning/disinfectant products being used and whether there is a risk of splash.
- Gloves and gowns should be removed carefully to avoid contamination of the wearer and the surrounding area. Be sure to clean hands after removing gloves.
- If gowns are not available, coveralls, aprons or work uniforms can be worn during cleaning and disinfecting. Reusable (washable) clothing should be laundered afterwards. Clean hands after handling dirty laundry.

- Gloves should be removed after cleaning a room or area occupied by ill persons. Clean hands immediately after gloves are removed.
- Cleaning staff should immediately report breaches in PPE such as a tear in gloves or any other potential exposures to their supervisor.
- Cleaning staff and others should clean hands often, including immediately after removing gloves and after contact with an ill person, by washing hands with soap and water for 20 seconds. If soap and water are not available and hands are not visibly dirty, an alcohol-based hand sanitizer that contains at least 60% alcohol may be used. However, if hands are visibly dirty, always wash hands with soap and water.
- Follow normal preventive actions while at work and home, including cleaning hands and avoiding touching eyes, nose, or mouth with unwashed hands.
  - Additional key times to clean hands include:
    - After blowing one's nose, coughing, or sneezing.
    - After using the restroom.
    - Before eating or preparing food.
    - After contact with animals or pets.
    - Before and after providing routine care for another person who needs assistance such as a child.

Additional considerations for employers

- Employers should work with their local and state health departments to ensure appropriate local protocols and guidelines, such as updated/additional guidance for cleaning and disinfection, are followed, including for identification of new potential cases of COVID-19.
- Employers should educate staff and workers performing cleaning, laundry, and trash pick-up activities to recognize the symptoms of COVID-19 and provide instructions on what to do if they develop symptoms within 14 days after their last possible exposure to the virus. At a minimum, any staff should immediately notify their supervisor and the local health department if they develop symptoms of COVID-19. The health department will provide guidance on what actions need to be taken.
- Employers should develop policies for worker protection and provide training to all cleaning staff on site prior to providing cleaning tasks. Training should include when to use PPE, what PPE is necessary, how to properly don, use and doff PPE, and how to properly dispose of PPE.

- Employers must ensure workers are trained on the hazards of the cleaning chemicals used in the workplace in accordance with OSHA's Hazard Communication standard.
- Employers must comply with OSHA's standards on Bloodborne Pathogens, including proper disposal of regulated waste, and PPE.

https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/cleaning-disinfection.html#Cleaning

Transporting residents

Facilities may provide transportation for residents to and from the facility. The following guidelines are recommended for safe resident transportation in facility vehicles:

- The driver should screen all passengers for fever (temperature) and COVID-19 symptoms and exposure before entering the vehicle. If fever or COVID-19 symptoms are present or exposure has occurred or resident is positive for COVID, the passenger should not be allowed entry into the transportation vehicle, unless leaving the facility to receive essential medical care. Other residents or non-essential staff should not be allowed in the vehicle.
- Provide EPA approved hand sanitizer in the vehicle.
- Reduce vehicle occupancy to accommodate social distancing.
- Identify or mark seats available in the vehicle that are at least 6 feet apart.
- Passengers should wear a facemask.
- Occupants of these vehicles should avoid or limit close contact (within 6 feet) with others. The use of larger vehicles such as vans is recommended when feasible to allow greater social (physical) distance between vehicle occupants.
- Clean and disinfect surfaces in the vehicle with EPA approved chemicals and disinfectants after each use.
- Avoid, if possible, to transport suspected or confirmed COVID-19 residents.
- In the event a resident suspected or confirmed with COVID-19 must be transported using facility vehicles, it is recommended the driver wear an N95 respirator or facemask (if a respirator is not available) and eye protection such as a face shield or goggles (as long as they do not create a driving hazard), and the passenger should wear a face mask or cloth face covering.
- Drivers should wear a mask, practice regular hand hygiene, and avoid touching their nose, mouth, or eyes.

Cleaning and disinfection for non-emergency transport vehicles

The following are general guidelines for cleaning and disinfecting transportation vehicles.

- At a minimum, clean and disinfect commonly touched surfaces in the vehicle at the beginning and end of each shift and between transporting passengers. Ensure that cleaning and disinfection procedures are followed consistently and correctly, including the provision of adequate ventilation when chemicals are in use. Doors and windows should remain open when cleaning the vehicle. When cleaning and disinfecting, individuals should wear disposable gloves compatible with the products being used as well as any other PPE required according to the product manufacturer's instructions. Use of a disposable gown is also recommended, if available.
- For hard non-porous surfaces within the interior of the vehicle such as hard seats, arm rests, door handles, seat belt buckles, light and air controls, doors and windows, and grab handles, clean with detergent or soap and water if the surfaces are visibly dirty, prior to disinfectant application. For disinfection of hard, non-porous surfaces, appropriate disinfectants include:
    - EPA's Registered Antimicrobial Products for Use Against Novel Coronavirus SARS-CoV-2, the virus that causes COVID-19. Follow the manufacturer's instructions for concentration, application method, and contact time for all cleaning and disinfection products.
    - Diluted household bleach solutions prepared according to the manufacturer's label for disinfection, if appropriate for the surface. Follow manufacturer's instructions for application and proper ventilation. Check to ensure the product is not past its expiration date. Never mix household bleach with ammonia or any other cleanser.
    - Alcohol solutions with at least 70% alcohol.

- For soft or porous surfaces such as fabric seats, remove any visible contamination, if present, and clean with appropriate cleaners indicated for use on these surfaces. After cleaning, use products that are EPA-approved for use against the virus that causes COVID-19 and that are suitable for porous surfaces.
- For frequently touched electronic surfaces, such as tablets or touch screens used in the vehicle, remove visible dirt, then disinfect following the manufacturer's instructions for all cleaning and disinfection products. If no manufacturer guidance is available, consider the use of alcohol-based wipes or sprays containing at least 70% alcohol to disinfect.
- Gloves and any other disposable PPE used for cleaning and disinfecting the vehicle should be removed and disposed of after cleaning; wash hands immediately after removal of gloves and PPE with soap and water for at least 20 seconds, or use an alcohol-based hand sanitizer with at least 60% to 95% alcohol if soap and water are not available. If a disposable gown was not worn, work uniforms/clothes worn during cleaning and disinfecting should be laundered afterwards using the warmest appropriate water setting and dry items completely. Wash hands after handling laundry.

Definitions

Cloth face covering: Textile (cloth) covers that are intended to keep the person wearing one from spreading respiratory secretions when talking, sneezing, or coughing. They are not PPE and it is uncertain whether cloth face coverings protect the wearer**.** Guidance on design, use, and maintenance of cloth face coverings is included in the list of resources in Section J.

Facemask: Facemasks are PPE and are often referred to as surgical masks or procedure masks. Use facemasks according to product labeling and local, state, and federal requirements. FDA-cleared surgical masks are designed to protect against splashes and sprays and are prioritized for use when such exposures are anticipated, including surgical procedures. Facemasks that are not regulated by FDA, such as some procedure masks, which are typically used for isolation purposes, may not provide protection against splashes and sprays.

Respirator: A respirator is a personal protective device that is worn on the face, covers at least the nose and mouth, and is used to reduce the wearer's risk of inhaling hazardous airborne particles (including dust particles and infectious agents), gases, or vapors. Respirators are certified by the CDC/NIOSH, including those intended for use in health care. Refer to the Appendix for a summary of different types of respirators.

Mild Illness: Individuals who have any of the various signs and symptoms of COVID-19 (e.g., fever, cough, sore throat, malaise, headache, muscle pain) without shortness of breath, dyspnea, or abnormal chest imaging.

Moderate Illness: Individuals who have evidence of lower respiratory disease by clinical assessment or imaging, and a saturation of oxygen (SpO2) ≥94% on room air at sea level.

Severe Illness: Individuals who have respiratory frequency >30 breaths per minute, SpO2 <94% on room air at sea level (or, for residents with chronic hypoxemia, a decrease from baseline of >3%), ratio of arterial partial pressure of oxygen to fraction of inspired oxygen (PaO2/FiO2) <300 mmHg, or lung infiltrates >50%.

Critical Illness: Individuals who have respiratory failure, septic shock, and/or multiple organ dysfunction.

Resources

- Updated Health care Infection Prevention and Control Recommendations in Response to COVID-19 Vaccination
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/infection-control-after-vaccination.html
- Interim Clinical Considerations for Use of COVID-19 Vaccines Currently Authorized in the United States
  https://www.cdc.gov/vaccines/covid-19/info-by-product/clinical-considerations.html
- Nursing Home Visitation - COVID-19 (REVISED)
  https://www.cms.gov/files/document/qso-20-39-nh-revised.pdf
- CDC website: www.cdc.gov
- What you should know about COVID-19 to protect yourself and others:
  https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf
  https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/prevention.html
- Cleaning and Disinfecting your Home:
  https://www.cdc.gov/coronavirus/2019-ncov/prevent-getting-sick/disinfecting-your-home.html
  https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2
- Preventing the Spread of COVID-19 in Retirement Communities and Independent Living Facilities (Interim Guidance):
  https://www.cdc.gov/coronavirus/2019-ncov/downloads/guidance-retirement-communities.pdf
- Considerations When Preparing for COVID-19 in Assisted Living Facilities
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/assisted-living.html
- Hand Hygiene:
  https://www.cdc.gov/handwashing/
- PPE:
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/ppe-strategy/index.html
  https://www.cdc.gov/coronavirus/2019-ncov/hcp/using-ppe.html

- Discontinuation of Isolation for Persons with COVID-19 Not in Health care Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-in-home-residents.html
- Return to Work: https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html
- Cleaning and Disinfection for Non-emergency Transport Vehicles: https://www.cdc.gov/coronavirus/2019-ncov/community/organizations/disinfecting-transport-vehicles.html
- CDC Poster cloth face covering: https://www.cdc.gov/coronavirus/2019-ncov/downloads/DIY-cloth-face-covering-instructions.pdf
- CDC/APIC Poster PPE: https://www.cdc.gov/hai/pdfs/ppe/ppe-sequence.pdf https://www.cdc.gov/coronavirus/2019-ncov/downloads/A_FS_HCP_COVID19_PPE.pdf http://www.apic.org/Resource_/TinyMceFileManager/consumers_professionals/APIC_DosDontsofMasks_hiq.pdf
- CDC Poster - What you should know about COVID-19 to protect yourself and others: https://www.cdc.gov/coronavirus/2019-ncov/downloads/2019-ncov-factsheet.pdf
- Monitoring residents and staff during suspected respiratory illness cluster/outbreak tool: https://www.cdc.gov/longtermcare/pdfs/LTC-Resp-OutbreakResources-P.pdf
- CDC's Strategies to Mitigate Health care Personnel Staffing Shortages: https://www.cdc.gov/coronavirus/2019-ncov/hcp/mitigating-staff-shortages.html
- Additional information about cohorting residents and establishing a designated COVID-19 care unit is available in the Considerations for the Public Health Response to COVID-19 in Nursing Homes (can tailor to group homes): https://www.cdc.gov/coronavirus/2019-ncov/hcp/nursing-homes-responding.html
- Strategies for Optimizing the Supply of N95 Respirators: https://www.cdc.gov/coronavirus/2019-ncov/hcp/respirators-strategy/index.html
- OSHA Respiratory Protection Program Guidelines: https://www.osha.gov/enforcement/directives/cpl-02-02-054
- Nursing Home Visitation - COVID-19 https://www.cms.gov/files/document/qso-20-39-nh.pdf

Note: CDC guidelines are subject to change as more is learned about COVID-19. Please visit the CDC website regularly to check for updated information.

Appendix A – Guidelines for Residential Facilities for Groups with Greater than 10 Beds
Cohorting Plan for Residential Facilities for Groups with greater than 10 Beds (to be implemented when a COVID-19 infection is suspected or identified)
Residential facilities for groups with greater than 10 beds should implement a cohorting plan when a case of COVID-19 infection is suspected or identified in the facility.

Facilities with the capacity to do so should identify red (Isolation), yellow (Quarantine) and green (COVID-19-free) zones where residents can be cohorted based on their symptoms and exposure risks to COVID-19. Facilities are also recommended to establish a transitional zone (gray zone) for Newly admitted/readmitted residents with no symptoms of COVID-19 with an undetermined exposure history.

The residents will be placed in different zones based on meeting certain criteria as follows:

- Residents belonging to Red (Isolation) zone:
  - Confirmed COVID-19 Cohort/Unit for residents
  - Both asymptomatic & symptomatic residents with confirmed SARS-CoV-2
  - All residents in the red zone should be on isolation precautions per CDC guidelines and health care workers should wear personal protective equipment as per the CDC.
- Residents belonging to Yellow (Quarantine) Zone:
  - All residents who may have been exposed to confirmed COVID-19.
  - Several factors have to be taken into consideration in order to determine the risk of exposure. These factors include (but are not limited to) suspected mode of COVID-19 acquisition (for the positive resident), movement of the resident with COVID-19 infection within the facility prior to the diagnosis, a facility's policies on universal masking and visitation, compliance of staff with infection control protocols and the number of residents with suspected or confirmed COVID-19 infection in a unit.
  - Example of residents who may qualify for being in the yellow zone: All exposed residents of a single unit/hallway/neighborhood where residents tested positive for COVID-19.
  - All residents in the yellow zone should be on precautions per CDC guidelines and health care workers should wear personal protective equipment as per CDC.
- Residents belonging to Green (COVID-free) Zone:
  - Residents with no known exposure to COVID-19
  - Residents that have met the CDC Criteria for Discontinuation of Transmission-Based Precautions or who have completed their quarantine from the last date of known exposure and have shown no symptoms throughout the quarantine period.
  - All residents without symptoms who are not considered to be exposed.

Note: If there are confirmed COVID-19 residents in many different units/hallways/neighborhoods, then there may not be a true green zone in that residential facilities for groups (at least at that point of time), as everyone is going to be considered exposed.

- Residents belonging to Gray (Transitional) Zone:
  - Newly admitted/readmitted residents with no symptoms of COVID-19 with an undetermined exposure history.
  - Full PPE, including the use of N95 masks, should be worn by caregivers providing care to residents in the transitional zone.

If the resident remains without symptoms at the end of day 14, the resident may be moved to the green zone. All residential facilities for groups (if able to) should consider establishing a transitional zone for new admissions, readmissions even regardless of facility COVID status.

Strategies to establish red, yellow, and green zones.

Scenario 1:

If residential facilities for group has space/rooms available then it will be preferred to establish red, yellow, and green zones in geographically distinct areas within the facilities.

- For example, if a facility has an empty unit, then the confirmed COVID-19 positive residents will be transferred immediately to that area for isolation which will be considered the red zone.
- Depending on exposure risk assessment the unit from where the residents were moved from will now be considered a yellow zone.
- The rest of the facility will be considered a green zone if it is established that residents in those units/areas have not been exposed.

Scenario 2:

If space is limited, red and yellow zones can be established within the same unit/hallway/neighborhood.

- For example, initially when a resident is diagnosed with confirmed COVID-19 and there is no isolation area available in the facility, the resident room will be considered the red zone and the resident will stay in his/her own room.
- As much as possible, this confirmed case should be moved to the end of that hallway.
- The rest of the shared hallway/neighborhood may become the yellow zone (depending on exposure risk assessment).
- All other units in the facility will be considered a green zone if it is established that residents in those units have not been exposed.
- If the resident in the above example has a roommate, the roommate should be stay within the yellow zone. (Note: Do not transfer the roommate to green zone).

If confirmed COVID-19 cases are identified in more than one unit/hallway/neighborhood or in both north and south hallways. The best strategy will be to move all COVID-19 positive residents into one hallway (cohort confirmed positive residents at one end of that hallway this will be considered the red zone).

Similarly, move all quarantine/exposed residents to the other hallway, which will now be considered a yellow zone. This is appliable only during surge outbreak in the yellow and red zones since all residents in this area will consider exposed.

If the facility has additional hallways or units that are geographically distinct from the north and south hallway (and no exposure is suspected), then those units/hallways will be considered the green zone. However, if everyone is considered exposed then there is no true green zone in the facility at that point.

Staffing Strategies:

The facility should implement a plan to control transmission of COVID-19 by dedicating health care personnel (HCP) to residents that are confirmed COVID-19 positive.

The facility should demonstrate an effort to limit rotations of HCP to different cohorts/units.

HCP must be educated on the facility's cohorting action plan in response to a COVID-19 positive resident or a resident becoming symptomatic.

The facility should follow their COVID-19 specific infection control plan when moving residents from the red zone to the yellow zone or from the yellow zone to the green zone. Follow infection prevention and control procedures very strictly to avoid transmission between zones.

Figure: Cohorting residents in the long-term care facilities

Red Zone (Isolation zone) **COVID-19 Cohort/Unit for residents**	-Both asymptomatic & symptomatic residents with confirmed SARS-CoV-2 (PCR) -Only PCR Positive, **NOT** Antigen.
Yellow Zone (Quarantine zone) **Quarantine Cohort/Unit and PUI**	-Residents with known exposure/contact with confirmed COVID-19 cases. -Or a positive antigen test.
Green Zone (COVID-19 free zone) **COVID-19 Free Cohort/Unit for asymptomatic residents that tested negative SARS-CoV-2**	-Residents with no known exposure to COVID-19. -Residents that have met the CDC Criteria for Discontinuation of Transmission-Based Precautions or who have completed their quarantine from the last date of known exposure and have shown no symptoms throughout the quarantine period.
COVID19 Gray Zone (Transitional zone) **New admission / Readmission**	-Residents who are newly admitted/ readmitted with no symptoms of COVID-19 with an undetermined exposure history. -They are kept in this zone for 14 days and if the resident remains asymptomatic at the end of 14 day, the resident maybe moved to Green Zone. -If they develop symptoms or test antigen positive, move to Yellow Zone. -If they test PCR positive, move to Red Zone.

Appendix B - COVID-19 Admission Intake Screening Tool

Name of Resident/Resident: _____

Date of Referral: _____

Date of Admission: _____

Date of COVID-19 Diagnosis: _____

Use this screening tool for residents/residents who have had a confirmed COVID-19 test to determine if the resident/resident has met the CDC's Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 in Health care Settings for the purposes of admitting residents/residents into your facility. A test-based strategy is no longer recommended by the CDC as the majority of cases who meet the CDC's criteria for the discontinuation of transmission-based precautions are no longer infectious.

1. **Is the resident/resident fully vaccinated with either the two-dose vaccine (plus 14 days) or the single dose vaccine (plus 14 days)?**

Yes_____
No_____
Partially Vaccinated_____

2. **Does the resident/resident have symptoms at time of referral?**

No _____ (Asymptomatic – does not have symptoms)
For residents who were **asymptomatic** throughout their infection, Transmission-Based Precautions may be discontinued when at least 10 days have passed since the date of their first positive viral diagnostic test (For asymptomatic residents that have severe to critical illness or immunodeficiency, Transmission-Based Precautions may be discontinued when at least 20 days have passed).
Yes _____ (Symptomatic – has symptoms)

3. Symptoms:

a. Date of Onset *(per acute care hospital):* _____
b. Description of Symptoms: _____
_____
_____
_____
c. Have the symptoms improved?
Yes _____
No _____
(If symptoms have not improved transmission-based precautions must continue)

4. Date of Last Fever (without use of fever reducing medication): _____

(If date of last fever is within the last 24 hours transmission-based precautions must continue)

5. Is the resident/resident severely immunocompromised?

Yes _____
No _____

6. Severity of illness: (Circle one, if applicable. If not applicable, do not circle)

a. Mild to Moderate Illness (*not severely immunocompromised*):
At least 10 days have passed since symptoms first appeared

b. Severe to Critical Illness ***OR*** *Severely Immunocompromised:*
At least 20 days have passed since symptoms first appeared

(If either of the above criteria is not met transmission-based precautions must continue)

Discontinuation of Transmission-Based Precautions

If symptoms have improved **AND** at least 24 hours have passed *since last* fever without the use of fever-reducing medications **AND** either 10 days or 20 days have passed, regarding severity of illness, the transmission-based precautions can be discontinued.

Note: Facilities must only admit residents/residents that are within the level of care appropriate for their facility type.

7. Discharge Summary Received *(within 24 hours of admission)*

_____Yes _____No

Admission of residents/residents to a nursing home or other long-term care facility such as a residential facility for groups/assisted living

- If Transmission-based precautions *are still required*, the resident should go to a facility with an ability to adhere to infection prevention and control recommendations for the care of residents with SARS-CoV-2 infection. The resident should be placed in a location designated to care for residents with SARS-CoV-2 infection.
- If transmission-Based Precautions *have been discontinued*, the resident does not require further restrictions, based upon their history of SARS-CoV-2 infection.

Resource

Discontinuation of Transmission-Based Precautions and Disposition of Residents with COVID-19 in Health care Settings (Interim Guidance): https://www.cdc.gov/coronavirus/2019-ncov/hcp/disposition-hospitalized-residents.html

Appendix C: Risk Assessment and Infection Control Recommendations for Returning Residents:

This risk assessment template should be used as a framework to guide COVID-19 infection prevention policy and practices for resident outings into the community.

This guidance can be used for non-medical community activities (e.g., therapeutic home visits, shopping, etc.) and for medical visits (e.g., dentist, outpatient clinic visit, outpatient dialysis, etc.). For each visit utilize the risk assessment tool on page two to determine if the visit was low, medium, or high risk, so you may implement the appropriate interventions, based on the risk score, to keep residents safe.

Fully vaccinated residents are equal to or greater than two weeks following receipt of the second dose in a two-dose series, or equal to or greater than four weeks following receipt of one dose of a single-dose vaccine.

During visits in the community, residents (whether vaccinated or unvaccinated) should adhere to the core principles of COVID-19 infection prevention, including effective hand hygiene, and use of face-coverings as source control. Facilities should:

- Screen and increase monitoring for signs and symptoms of COVID-19.
- Test a resident for COVID-19 if signs or symptoms are present or if a resident or their family reports possible exposure to COVID-19 while outside the facility. A facility may also opt to test residents without signs or symptoms if they leave the facility frequently or for a prolonged length of time, such as over 24 hours. For more information on testing guidelines see CMS memorandum QSO-20-38-NH (https://www.cms.gov/files/document/qso-20-38-nh.pdf).
- Place the resident on transmission-based precautions (TBP) if the resident or family member reports possible exposure to COVID-19 while outside of the facility, or if the resident has signs or symptoms of COVID-19 upon return. Please note that residents and loved ones should report to facility staff if they have had any exposure to COVID-19 while outside of the facility.

In addition to the above interventions, on a resident's return to the facility from a leave of absence, facilities should use the following risk assessment template to guide COVID-19 infection prevention policy and practices.

Risk Assessment Template for All Residents, Regardless of Vaccination Status:

A. Prolonged contact with a person who has COVID-19 ☐ Yes ☐ No
   - If "yes," consider high risk.
   - If the above question is "no," go to next set of questions.

B. Is the family and/or persons that the child is visiting fully vaccinated? ☐ Yes ☐ No

C. Has the resident been fully vaccinated? ☐ Yes ☐ No

   - If the response to question B and/or C above is "Yes," then consider low risk and the risk assessment is complete.
   - If the response to both of the questions (B and C) above is "No," then proceed to the risk assessment below.

Risk Assessment Template for Unvaccinated or Not Fully Vaccinated Residents

Unvaccinated or Not Fully Vaccinated Residents:

Assign 1 point to each "Yes"	Yes or No?	Points
Fourteen days prior to visit, family participated in activity with greater than five people	Yes No	
Took resident out of home to high-risk area (ex: crowded areas, shopping mall, another home, etc.)	Yes No	
During visit, gathering at home or any indoor activity with greater than five people	Yes No	
Duration of activity more than one hour with any unvaccinated person	Yes No	
Persons in contact with resident that are unmasked and/or do not maintain physical distancing of at least 6 feet for any portion of the visit	Yes No	
Contact with someone who is having COVID like symptoms or tests positive for COVID.	Yes No	
	Total Points:	

Based on the results of the above risk assessment, facilities should implement the following actions based on the level of risk determined:

Score	Risk Level	Example Activities	Recommended Actions for Facility
0 - 1	**Low**	• Walk in an uncrowded park • Doctor's appointment where universal masking is required • Home visits with fully vaccinated extended family/people present.	Educate on infection prevention, hand hygiene, and respiratory/cough etiquette. Actively screen residents daily for symptoms, before leaving and after returning.
2 - 3	**Medium**	• Retail shopping with social distance maintained	Implement all Low-risk actions AND refrain from group activities for 14 days since most recent outing.
4 - 6	**High**	• Eating in a crowded restaurant • Social public gatherings • Home visits with unvaccinated or not fully vaccinated extended family/ people present • Casino visits	Implement all Low and Medium risk actions AND place in quarantine for 14 days since most recent outing.

Local public health authorities determine and establish the quarantine options for their jurisdictions. CDC currently recommends a quarantine period of 14 days for congregate-living environments. However, based on local circumstances and resources, the following options to shorten quarantine are acceptable alternatives.

- Quarantine can end after Day 10 without testing and if no symptoms have been reported during daily monitoring.
    - With this strategy, residual post-quarantine transmission risk is estimated to be about 1% with an upper limit of about 10%.

- *When diagnostic testing resources are sufficient and available (see bullet 3, below),* then quarantine can end after Day 7 if a diagnostic specimen tests negative and if no symptoms were reported during daily monitoring. The specimen may be collected and tested within 48 hours before the time of planned quarantine discontinuation (e.g., in anticipation of testing delays), but quarantine cannot be discontinued earlier than after Day 7.
    - With this strategy, the residual post-quarantine transmission risk is estimated to be about 5% with an upper limit of about 12%.

In both cases, additional criteria (e.g., continued symptom monitoring and masking through Day 14) must be met and are outlined in the full text.

Note: Please have your visitation plan available at your facility for review by surveyors during an inspection. You are **not** required to submit your plan to the Bureau of Health Care Quality and Compliance (HCQC) for prior approval.

References:

- CDC: Preparing for COVID-19 in Nursing Homes
- CDC: Interim Infection Prevention and Control Recommendations for Health care Personnel During the Coronavirus Disease 2019 (COVID-19) Pandemic
- CDC: Considerations for Preventing Spread of COVID-19 in Assisted Living Facilities
- CDC: When to Quarantine